LEHIGH VALLEY
HOSPITAL AND
HEALTH NETWORK

PROGRESS NOTES

Medical Staff

April, 2003 Volume 15, Number 4

In This Issue . . .

From the President

"Stop; look; listen"
-Ralph R. Upton, 1912
(Slogan developed for railway crossings)

The months are slipping past rapidly. It's already April, 2003, and this term of presidency is one-sixth over. In fact, counting vacations, weekends, nighttime, occasional sick days, a snow day here and there, and, of course, the four months at the end when it's a lame duck presidency, it's really pretty much kaput. So it's time to follow Ralph's advice, take a look around, and consider what else we need to accomplish around here. As we approach the rebirth of spring and welcome the return of the sun, it is an opportune time to consider how to make life just a little better for the Medical Staff.

Ed Mullin was kind enough to chair an ad hoc committee on physician morale that met over the winter to stop, look and listen to the mood of the Medical Staff and comment on what we could do to make things better. The report landed on the Medical Staff Services Office desk a couple of weeks ago. Our thanks go out to the thoughtful members of the committee who gave selflessly of their time: Ed Mullin, Brian Nester, Glenn Kratzer, Jim Goodreau, Jack Nuschke, Scott Beman, Bill Iobst, Don Belmont, Joe Candio, Ed Geosits, Larry Karper, Dorothy Hartman, Kyle Walker, Joe Neri, Bill Swayser, and Larry Glazerman. The charge to the group was to identify and enumerate sources of negative morale, discuss possible solutions, and recommend solutions to Troika for consideration. On behalf of Troika, I would like to extend my thanks to the members of this committee for their reasoned and thoughtful advice.

The committee identified major issues that have had an impact on the physician morale at Lehigh Valley Hospital. External factors, such as the malpractice issue and declining reimbursements, in company with increasing office overheads, have conspired to increase the pressure on physicians to work longer hours with no anticipation of improvements in the future. The general malaise of the country that relates to the fear of a debated war and a faltering economy only serves to increase the anxiety surrounding these factors. For many physicians, working harder and longer is no longer an option. Their families are telling them it's time for them to stop, look and listen, and not drift further away from their loved ones.

Continued on next page

Internal factors affecting morale include a sense that physicians are not as professionally appreciated as they used to be. They do not feel as well supported by their peers, by the hospital, and by the community. The committee voiced the concern that hiring new partners to help with the workload is becoming more difficult due to the deteriorating environment of payment. Physicians coming out of training have more debt with higher expectations for income than is realistic in certain parts of the country such as Pennsylvania.

The committee noted increased time pressures. There is an increasing volume of work, which is documented by the rising ED visit rate, divert hours and the frequent level 4 alerts. The shorter length of stay, faster inpatient census turnover, and a shift of surgical caseload from inpatient to outpatient have all made every minute a premium event. Physicians feel that there is less time to work with each patient, and less time for consideration and reflection. The committee wondered whether "Anybody still noticed what we do?"

The committee noted a perceived lack of support from the Administration for the Medical Staff. They noted insufficient communication among physicians, between physicians and Administration, and vice versa. They also noted a lack of availability from the Medical Staff leadership, a concern that was distressing to Troika, but appreciated in the spirit of telling 'the brutal truth'. The committee noted the lack of a physician voice in "policy-making at hospital, governmental, and societal levels."

In terms of support, the committee mentioned the many roadblocks to efficient practice. "If we could do our job efficiently, we could get through some of the work we need to do." OR start times continue to be late, turnover time between cases is still in the red zone despite laser-like attention by the Department of Surgery and the OR management team. These last two items were of particular concern to the surgeons on the committee. The committee brought up the issue of the CAPOE learning curve and its effect on rounding times. They discussed the phone auto attendant, which sometimes keeps physicians waiting to contact each other. They discussed stop orders that often seem to have no rhyme or reason. They discussed queries of discharge diagnoses that, at times, seem irrelevant and irritating. They noted that each of these issues in and of itself is not a compelling problem, but in the aggregate conspire to make the environment of practice burdensome.

The committee discussed the heterogeneity of the Medical Staff, with various relationships between physicians on staff and the hospital itself -- private practice physicians based primarily at Cedar Crest or Muhlenberg, private practice physicians based primarily at other hospitals, physicians employed by LVPG (of which there is an internal heterogeneity with Chairs, program leaders, educators, management, and primary care physicians), physicians working in exclusive contract with the hospital, and other arrangements. The committee noted the strength of a pluralistic Medical Staff, but also the stresses between 'competing' groups.

Finally, there was a concern on the part of the committee that the Press-Ganey hospital surveys may not reflect the totality of the hospital experience. "They don't seem to reflect what we see in the hospital."

It is easier to cast arrows than to build new foundations. The committee worked hard on finding some solutions to offer in improving physician morale. The key recommendations had to do with improved consideration and improved communication. The committee recommended that the Medical Staff structure needs to be more responsive to the needs of physicians in the hospital setting. The committee also recommended that the Administration and Chairs be more considerate of the needs and concerns of the Medical Staff. They felt that it was important that the hospital be as concerned about the effective use of the physicians' time as it is about other priorities. They recommended that the Medical Staff leadership act more in an advocacy or ombudsman role for the Medical Staff. In addition, they felt there should be a Medical Staff Concierge, with the ability to get things done.

Troika listened to the comments of the committee closely and took away the following points. First, that even among loyal, closely aligned physicians, there is a sense that all is not well. Second, that we need to stop, look and listen to this perception/reality/mood/concern and take it seriously. Third, we need to collectively remember that "doctors are people too."

As a response to these concerns expressed by the committee, Troika has recommitted itself to efforts to improve the practice environment for physicians. Our sense is that while there are external factors that cannot be controlled which weigh heavily on morale, there are substantive efforts we can make as a Medical Staff and institution to develop a friendly and responsive environment for physicians. Troika is in the process of developing a series of 'Culture of Delight' activities focused on physician advocacy, recognition, satisfaction, and awareness, which we hope will in some way improve the environment for our Medical Staff.

a. Physician Orientation and Reconnection. A subcommittee of Troika and the Medical Staff Services staff is working to develop a new physician orientation program. This will be CD-ROM based or available on the web and aims to give access to all of the resources needed for a new physician. This program should be ready by May of 2003, and will be offered to new physicians and on request to established physicians if they feel there are areas they are unsure about.

Continued on next page

b. 402-DOCS line. Along the line of a concierge service, the Medical Staff Services office has established a dedicated phone number that doctors can call to get issues worked on. If you have a problem which is niggling you, parking issues, concerns about a dirty hallway, or if you don't know where to go with a simple issue, you will be able to call this line and the Medical Staff Services office will be more than happy to assist you to help resolve this issue with a minimum of time and effort on your part.

c. The Ghost Buster Service. Troika will be offering a new communication service to the docs. For higher level issues, concerns about who to talk to on a political front, where to go with a service issue, what to do about complex hospital interactions, who you gonna call? Ghost Busters! The Past President of the Medical Staff will be charged with answering your questions in these 'higher level' areas, helping you to know where to go with an issue and getting you connected.

d. Troika Sleigh Rides. Watch out, we're goin' on the road. We are hitching up the sled, waxing our runners, and taking the bit in our teeth. Troika sleigh rides began in March. Look for us wandering the hallways, meeting, greeting, and listening to our colleagues at all sites. Troika sleigh rides are designed to bring us out to where you are. Nurses, do you have an issue with a physician? Let us know. Support partners, want to bring something up? Let us know. Docs, did you want to buttonhole Troika but didn't know how; watch for us and shuffle up to the sled to give us your earful.

e. Three Circles Awards. We are developing Three Circles Awards to give out to deserving members of the Medical Staff, as well as others on the hospital staff who have exemplified the characteristics of excellence in care, provision of a delightful environment of care, and service to the community. We will be giving out these awards on a regular basis, sometimes during our Sleigh Rides through the hospitals. Let us know if you have someone you feel deserves such an award, and we will be most delighted to honor them. Feel you deserve an award? Have a friend put you up for it. We look forward to letting you know how much you mean to all of us.

f. Physician Satisfaction Metric. We measure everything here in the hospital -- the falls, the mortalities, length of stay, Press-Ganey satisfaction, amps of morphine, number of red bags, bushels of broccoli used in the cafeteria. So why not measure physician satisfaction? In collaboration with Mr. Lou Liebhaber, we are working with an external consultant on how to sample the physician satisfaction on a regular basis.

g. "You Do the Score" Program. Troika has begun a process of self-analysis, in which we assess monthly how we are doing in various areas. We will be asking a random group of physicians to score us from time to time to give us feedback. How do you think we do on advocacy? How available are we for your concerns? How do we inform you? These and other issues are up to you to let us know how you feel.

h. CAPOE Prize Program. Since you were all at the last General Medical Staff meeting, you, of course, know that there will be a prize for utilization of CAPOE. Hat's off to I/S for coming up with a program to salute and reward physicians who adopt and use CAPOE early on.

i. General Medical Staff Drawing. Tired of paying your dues to the Medical Staff? Well, as an incentive to attend the quarterly meetings, you will have the opportunity to win a check to pay your dues. Three lucky members of the Medical Staff who attend the GMS meeting each quarter will win a year's relief from dues payment.

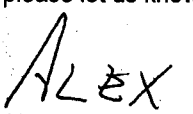
j. Stopping stop orders. In association with the P & T Committee and Fred Pane of the Pharmacy, Troika is encouraging a reassessment of stop orders. Many of these may no longer be necessary in an environment where stay is very short, and we may be able to reduce significantly the number of stop orders you have to work on. Stay tuned.

k. Pro Tempore feedback notes. We will be using Pro Tempore, our monthly email communication, to provide feedback about issues. This will be an attempt to keep you up to date on what's going on in various areas of the hospital.

Clearly, these activities will not fix all problems for all physicians. What we'd really like to do is simple. Fix malpractice for good and all. Raise insurance reimbursements to more healthy levels without in any way negatively affecting patients, employers, and the economy. Make every admission easy, all patients friendly, and all support staff above average.

While we can't fix everything, here is Troika's pledge to you. We will continue to listen and learn, taking what you tell us seriously. We will continue to relay 'what is going on in the trenches' to the Chairs and Administration. We will continue to problem solve issues with the existing structures. We will try to provide a balanced worldview to both the Medical Staff and Administration in our role as a vehicle for communication. And, above all, we will continue to take your concerns seriously.

If you have any suggestions or recommendations for us, please let us know.



Alexander D. Rae-Grant, MD
Medical Staff President

Farewell to Dr. Laskowski

Robert J. Laskowski, MD, Chief Medical Officer since 1995, recently bid farewell to his friends and colleagues at LVHHN. On April 14, he will begin his new post as President and CEO of the Christiana Hospital System in Delaware.

Best wishes, Dr. Laskowski. You will be deeply missed!

Plans for Interim Management Announced

Since January, when an announcement was made that Dr. Laskowski would leave LVHHN to become President and CEO of Christiana Hospital, much time has been spent examining the role of LVHHN's Chief Medical Officer to determine how to meet the challenges of the future. Following are details regarding the new structure for that office, the search for a new chief medical officer, and plans for interim management. These changes are effective April 1, 2003.

The office of chief medical officer will include all of the functions currently assigned to the position in addition to several new ones. Reporting to the chief medical officer will be all the clinical chairs, the senior vice president for quality and care management and the medical director of LVH-Muhlenberg.

To strengthen our emphasis on learning, a new position -- senior vice president for education and research -- has been created. Mark Young, MD, has accepted that position. Dr. Young will continue as chair of the Department of Community Health and Health Studies. His duties will expand to include the Center for Educational Development and Support and other educational functions.

Recognizing the importance of nurturing and deepening relationships with the medical staff, a senior vice president for physician practice and network development will be appointed. This individual will be responsible for centralized activities that focus on developing and growing physician practices. A physician leader will be recruited for this position in the near future.

Lou Liebhaber will chair the chief medical officer search committee with Tammy Jamison of HealthSearch, LVHHN's in-house physician recruiting service, serving as principal staff. Also serving on the committee will be:

Gregory Brusko, DO
David Caccese, MD
Terry Capuano
Michael Ehrig, MD
Jack Fitzgibbons, MD
Mary Kay Gooch
Alex Rae-Grant, MD
Mark Holtz
Michael Kaufmann, MD
Zubina Mawji, MD
Tom McLoughlin, MD
Terry Ryan-Mitlyng, MD

It is hoped that a new chief medical officer for LVHHN will be identified within the next six to 12 months. While the search progresses, Michael Weinstock, MD, has been asked to serve as interim chief medical officer. In his role as Chair of Emergency Medicine, Dr. Weinstock has done an outstanding job in developing staff, emphasizing education and research and expanding our Emergency Department capabilities. He will undoubtedly bring the same enthusiasm and dedication to this role. Richard S. MacKenzie, MD, will serve as interim Chair of Emergency Medicine.

New Chief of Cardiology Announced

Michael A. Rossi, MD, has been appointed Chief of the Division of Cardiology and Medical Director of The Regional Heart Center of Lehigh Valley Hospital and Health Network, effective April 28. This will continue the network's legacy of providing superior cardiac care, which began in 1974 when the organization launched the first open heart surgery program in the region. In this role, Dr. Rossi will lead LVHHN's clinical, educational and research initiatives related to the cardiac programs as they continue to evolve. The Regional Heart Center comprises LVHHN's full continuum of cardiovascular medical and surgical services at both the Cedar Crest & I-78 and LVH--Muhlenberg sites.

Dr. Rossi is an excellent physician who also is a highly skilled administrator, having served as president of The Heart Care Group. In his new leadership position, these proven abilities, his keen sense of fairness, and the respect of his peers will serve the network well as LVHHN continues to develop the high-quality cardiovascular services that best meet the needs of LVHHN's patients.

Dr. Rossi is a medical cardiologist who has expertise in nuclear cardiology, echocardiography and transesophageal echocardiography, advanced imaging techniques for diagnosing heart disease. He has been president of The Heart Care Group, P.C., the region's largest private practice of cardiologists and cardiothoracic surgeons, since 1997, when it was formed through the merger of two of the region's cardiology groups, Cardiology Care Specialists and Cardiovascular Associates. He joined Cardiology Care Specialists in 1992 and became its president in 1995.
As LVHHN's Chief of Cardiology and Medical Director of The Regional Heart Center, Dr. Rossi will relinquish his membership in The Heart Care Group, but will continue to provide patient care at LVHHN.

News from CAPOE Central

PACU Patients - Things to Remember When Using CAPOE

- CAPOE orders can be entered for any patient in the PACU. The PACU staff has been instructed to look on-line for orders.
- Please remember that for STAT orders, direct communication is still required (face-to-face or a phone call). To ensure high quality patient care, it is important that this communication process remain in place.
- Please remember to write in the chart that "Orders are On-line." This will help alert the staff to look on-line for the orders, and will reduce call backs to you asking for the orders. We have also created stickers that state, "Orders are On-line" and have placed these stickers in the PACU, in the ED, and in the OR's. If you cannot access the chart, then please call the PACU to alert them you have entered orders on-line. As the use of CAPOE increases, this issue will be resolved.
- When placing post-op orders, please remember to check off the 'Admit to PACU' order. It is usually located as the first order on all the post-op order sets. This order triggers a process that groups the post-op orders for the PACU staff, and alerts them that orders have been entered on the patient.

Recognition of Effort (ROE) Program

A consistent concern from the Medical Staff regarding CAPOE has been the time that it takes to learn and enter orders in CAPOE. During the past two years, we have worked hard with the CAPOE trained physicians to make the system as user friendly as possible. However, it is clear that there remains a time factor in learning the system.

As discussed at the General Medical Staff meeting on March 10, 2003, we are establishing the following two new programs.

In recognition of the learning curve, we are instituting a plan to compensate the Medical Staff for the educational commitment to learn to use the CAPOE system. You will be reimbursed over a four-month period for the impact on your efficiency while learning to enter orders on-line. The details of the program follow.

- Each month that a specified percentage of orders are entered on-line, you will receive $500.
- The percentage of on-line orders (of total orders placed on CAPOE units) required to receive reimbursement are as follows:
  - April, 2003 40% of total orders entered on-line
  - May, 2003 50% of total orders entered on-line
  - June, 2003 60% of total orders entered on-line
  - July, 2003 65% of total orders entered on-line
- The plan will begin in April 2003 for physicians that have already been trained. For physicians not yet trained, or new physicians, the program will begin two months after training date.
- To qualify, you must place a minimum of 50 total orders per month (written or entered on-line)
- If you have residents on your service during a month of the program, or utilize AHP's, the data used will be a total of orders placed by you and the residents assigned to your service or AHP's.

Bermuda Trip Monthly Drawing

After the four-month period, we plan to recognize those physicians who remain committed to the CAPOE effort. Each month, beginning in September 2003, there will be a drawing for a trip to Bermuda for two. To qualify to be entered in the drawing, you will need to have entered at least 60% of your total orders (on CAPOE units) on-line.

We believe that these programs help recognize the effort being made by the Medical Staff to adapt to the changes associated with CAPOE and take the time to learn to use the system.

Don Levick, MD, MBA, Physician Liaison, Information Services (610) 402-1426 (office) ❖ (610) 402-5100 7481 (pager)

Smallpox Update

As LVHHN continues its internal planning for the smallpox vaccination program, there are still many unknowns. The PA Department of Health began vaccinating public health employees on February 10. As of early March, 57 public health personnel have been vaccinated in Pennsylvania and a total of 12,680 across the United States. There is still no indication of when health care workers will begin receiving the vaccination.

Over 1,100 LVHHN employees considered to be "first responders" were sent a letter regarding smallpox vaccination requesting they indicate whether they would be interested in volunteering or not. At this time, the response rate has been just over 12% with a total of 163. Of those responding, 46 individuals have identified themselves as volunteers. Please encourage members of your staff who received a survey to return it even if they are not interested in volunteering.

A number of smallpox training sessions and videoconferences have been offered; you will continue to be notified by e-mail of any additional sessions. As the number of vaccinated individuals throughout the state and country increases, it becomes even more important that clinicians understand the types of vaccine reactions that might occur. If you are interested in having a presentation on smallpox at a department or clinic level meeting or would like a supply of educational materials, please contact Debra Geiger, Project Manager, at (610) 402-4589.

News from the HIM Department

New Name for PIM/IMNET

The electronic historical medical record has been in effect at Lehigh Valley Hospital since 1997, and at LVH-Muhlenberg since 2000. During this time, it has been referred to by several names. The system, when initially purchased, was called IMNET after the name of the company who developed the software. Since that time, IMNET was sold to McKesson HBOC and was renamed PIM (pathways image manager) and then changed to EPF (electronic patient folder) system. In the new release, it is now called HPF (horizon patient folder).

To avoid renaming the electronic medical record system every time the company changes names, the decision was made to call the LVHHN system the **Electronic Historical Medical Record (EHMR)**. After March 10, 2003, you will see this name on all the computer access buttons as well as references being made to the electronic medical record.

Documentation Quality

HIM and Patient Care Services have been working together to improve the quality of documentation while the patient is hospitalized. Some areas of special concern include:

- Patient Identification – Every page in the medical record must contain two forms of identification (preferably the name and the medical record or account number). If you remove or add a form to the patient's record, make sure the identification is correct. When documenting, make sure that you are documenting on the correct patient's record.

- Corrections in the medical record – Do not use White Out or obliterate information once documented in the record. Proper corrections to the medical record include (1) drawing a single line through the error, (2) documenting "error in charting," (3) making the correction and (4) dating and initialing the entry. Late entries should be made at the time they occur using the current date and time.

- Documentation outside form margins – Forms are designed with space for writing as well as margins. The document-imaging scanner will not pick up information that is outside the designated writing spaces on the forms. Blank pages on the back of forms should not be utilized for documentation. Please use a designated form with designated writing space.

If you have any questions regarding these issues, please contactmay be referred to Zelda Greene, Director, Health Information Management at 610-402-8330.

Expansion of Electronic Signature in EHMR

Effective April 7, 2003, physicians will be able to electronically sign all ancillary results (except diagnostic radiology) in the Electronic Historical Medical Record (EHMR), formerly called the PIM/IMNET system. Electronic signature in the EHMR will provide one-stop access and electronic signature functionality for the Medical Staff.

The new ancillary result process is as follows:

- Ancillary testing performed
- Results read/dictated by physician
- Results transcribed and available in IDX in preliminary format
- Results held for 24 hours in IDX for physician review and editing
- Results moved to EHMR for electronic signature
- Results electronically signed by physician

In accordance with the Medical Staff Bylaws and Medical Record Guidelines, physicians will have 15 days to electronically sign ancillary results. Physicians will be notified electronically of results pending signature. The Health Information Management (HIM) Department will also notify physicians of any delinquent signatures on Tuesday prior to the Wednesday suspension process.

If you have any questions regarding this process, please contact the HIM Department at (610) 402-8307.

402-DOCS

Something like a concierge service, in an effort to assist members of the Medical Staff with problems, issues, or concerns, the Medical Staff Services office has established a dedicated phone number that doctors can call to get a quick response. If you have a problem which is bothering you, parking issues, concerns about a dirty hallway, or if you don't know where to go with a simple issue, call **402-DOCS** and the Medical Staff Services office will be more than happy to assist you to help resolve this issue with a minimum of time and effort on your part.

Lehigh Valley Hospital Honored with Top Award for Quality in the Nation

Lehigh Valley Hospital and Health Network (LVHHN) is this year's only recipient of the prestigious National Quality Health Care Award. The award is presented annually by the National Committee for Quality Health Care (NCQHC) in partnership with ***Modern Healthcare*** magazine.

This award is presented to a health care provider that "embodies a vision for quality that embraces innovation and forward thinking, and establishes ways to measure and evaluate those processes to benefit the community," according to the National Committee for Quality Health Care guidelines.

"This honor is especially gratifying because it was earned by our entire hospital team doing what they do everyday to care for our community," said Elliot J. Sussman, MD, LVHHN's president and CEO. Dr. Sussman accepted the award at NCQHC's 25th Anniversary Annual Conference on March 25 in Washington, D.C.

In its tenth year, the award recognizes LVHHN for "demonstrating excellence in health care delivery through innovative leadership, patient satisfaction, performance assessments to measure improvement, employee input and involvement and recognition of achievements, sound financial management focused on meeting the needs of the entire community, and an integrated and cost-effective information system."

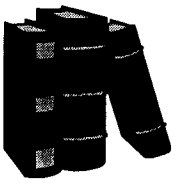
"The judges agreed that Lehigh Valley Hospital demonstrates strong patient-centered practices and a strong program to attract and maintain a workforce committed to delivering quality healthcare," said Catherine E. McDermott, NCQHC's president and CEO.

The National Quality Health Care Award is the latest of several national honors bestowed on LVHHN, its physicians, nurses and staff over the past 14 months.

News from the Libraries

Ovid Training

To arrange for instruction in the use of OVID's MEDLINE and its other databases, please contact Barb Iobst at (610) 402-8408.



Recently Acquired Publications

Library at 17th & Chew

- American Dental Association Starting Your Dental Practice: A Complete Guide.
- American Dental Association Associateships: A Guide for Owners and Prospective Associates.
- American Dental Association Valuing a Practice: A Guide for Dentists.
- American Dental Association Practice Options for the New Dentist: A Financial Guide.

Library at Cedar Crest & I-78

- American Psychological Association Publication Manual of the American Psychological Association 2001
- Kowalak. Best Practices: A Guide to Excellence in Nursing Care. 2003

Library at LVH-Muhlenberg

- American Psychological Association Publication Manual of the American Psychological Association 2001
- Ahya. Washington Manual of Medical Therapeutics. 2001.

Please forward new book suggestions to Barbara Iobst at the Cedar Crest & I-78 Library.

Safety Pearl of the Month

Misreading Medication names that end in "L"

Misreading of the terminal "L" in orders for both Tegretol and Amaryl resulted in dosing errors. "Tegretol300mg" was misinterpreted as 1300 mg, and "Amaryl2mg" as 12 mg. Ensure proper spacing and clear doses when writing medication orders.

Core Measures

Core Measures, a continuation of JCAHO's ORYX initiative, became effective as of July 1, 2002. All accredited hospitals are required to submit core measure data to JCAHO, via an approved performance measurement system. The first submission of data occurred in January 2003 and contained information about patients discharged from July 1 to September 30, 2002. Each hospital was required to select two core measure sets from a list of four possibilities. The four possibilities are congestive heart failure, acute myocardial infarction, community acquired pneumonia and pregnancy and related conditions. LVHHN chose congestive heart failure (CHF) and acute myocardial infarction (AMI). The performance measurement indicators for AMI include aspirin at arrival, aspirin prescribed at discharge, ACEI for patients with left ventricular systolic dysfunction, adult smoking cessation, beta blocker prescribed at discharge, beta blocker at arrival, median time to thrombolytics, median time to PTCA and inpatient mortality. The performance measurement indicators for CHF include left ventricular function assessment, ACEI for left ventricular systolic dysfunction, adult smoking cessation and discharge instructions (activity level, diet, discharge medications, follow-up appointment, weight monitoring and what to do if the symptoms worsen).

The information about each of the performance measurement indicators is abstracted from the patient's medical record by the abstractors who perform the Atlas data collection. There are specific criteria for the abstraction and the results are available on the same timetable as the Atlas information. It is expected that JCAHO will be comparing LVHHN's data with other organizations, and when they come for survey in 2003, they will be asking questions about our improvement activities for the indicators noted previously.

The core measures are very similar to the quality of care measures identified by Quality Insights of Pennsylvania (QIP), the Quality Improvement Organization for Centers for Medicare and Medicaid Services. LVHHN has been alerted that QIP has public reporting as one of its goals so it will be to our benefit to begin work on those indicators where performance is less than 100%.

AMI – 1st Quarter FY'03 Results

	ASA @ Arrival	ASA @ D/C	ACEI for LVSD	Adult Smoking Counseling	Beta Blockers @ D/C	Beta Blockers on Arrival	Median Time PTCA	Inpt Mortality
LVH-CC	96.4%	96.9%	67.2%	77.8%	92.3%	94.2%	90 min	6.1%
LVH-M	100%	91.7%	83.3%	83.3%	94.7%	91.7%	103 min	4.3%

CHF – 1st Quarter FY'03 Results

	Discharge Instructions	LVF Assessment	ACEI for LVSD	Adult Smoking Counseling
LVH-CC	40.0%	95.2%	62.0%	16.7%
LVH-M	23.8%	91.4%	50%	16.7%

If you have questions about these measures, please contact either Susan Lawrence, Administrator, Care Management, at (610) 402-1765, or Ruth Davis, Director, Care Management, LVH-M, at (484) 884-2307.

Mt. Kilimanjaro or Bust!

by Edward M. Mullin, Jr., MD
Past President of the Medical Staff

I turn on my headlight in the darkness to locate my alarm clock. It is 5:20a.m., 27 degrees Farenheit in my tent, and it's time. We are at Crater Camp (18,750 ft.) and we will summit this morning. I roll up my sleeping bag, wrap myself in my fleece and parka, slip on my boots and make my way to the dining tent. My friend, Duncan, has been vomiting and feels weak. The rest of us have no appetite. Breakfast is not the usual porridge, eggs, fruit, bread with peanut butter, tea and hot water. I eat about 10 shortbread cookies and wash them down with Chai tea. I am ready. This is what I came for.

A dozen climbers start slowly up the final 600 feet led by our head guide, Jonas (who has summited 126 times). There is a tendency to keep your vision focused on the footsteps of the climber in front of you (like elephants in the circus), but every now and again, I look up to savor this final segment of the climb. The powerful African sun starts to glow below the horizon. The sky is cloudless every morning. A surprisingly powerful urge comes over me to yell at the mountain that we are coming, but I think this would alarm my climbing companions. Besides, it's quiet and we are all short of breath anyway. Halfway up, one of the stronger climbers from California sits down on a rocky ledge, shuts her eyes, and says she needs a few moments. I have not seen her do this before and I am concerned. We slowly pass her by and continue to ascend. A guide stays with her. Jonas chops footholds in the ice with his ax and it is getting colder and quite windy. I have fleece gloves with mitten shells on, but I am waiting for my hands and feet to regain sensation with the exercise, as they usually do. After 90 minutes of rock climbing, we reach a ledge. After clearing this ledge, I realize that this is Uhuru Point --the highest point in Africa (19,340 ft.). I am elated and feel a sense of fulfillment.

Gradually, we all make the summit as the sun peers over the horizon at 7:30 a.m. My friend, Duncan, needed a guide to carry his backpack for him, but ultimately he makes the ledge as well. Lots of hugs, congratulations, smiles. Our group is alone at the summit for almost 30 minutes of pictures and looking around. We are savoring this moment. It is quite windy and cold, but we expected this. We had started the previous Monday morning, so it was a full week of camping and climbing. I hope my camera (and my water) is not frozen.

About 50% of all Kili climbers do not make it to the summit due to problems with acclimatization to altitude. Not many take the Western Breach route like we did, but spend a whole day hanging out at 12,750 ft. Baranco Camp (taking day hikes) simply to help with acclimatization. Most take the so-called CocaCola route from Marangu Gate (a lot less scenic). About 7,000-10,000 climbers from all over the world come to climb the mountain yearly.

It was quite the adventure. We started out in the rain forest, and progressed to forest heather and rocky moor. One member of our group fell on the third day of the climb and fractured his ankle. As the team physician, I checked him out and it was an obvious fracture (even to a urologist). After discussion, the guides elected to carry this 170 lb. climber down the steep path to Baranco camp. They are incredibly strong. We splinted his ankle with a bi-valved plastic water bottle over layers of socks, secured with a lot of silk tape. It worked well and he was helicoptered out the next morning by Medivac from Nairobi. I managed assorted minor medical items from my fellow climbers, but the main discussion was about Diamox, pros and cons.

I was the only member of our Explorers Club group that had not done any sort of climbing before (does Doe Mountain count?). Most had been on treks in the Himalayas, or Mount Ranier, or Denali, etc. They asked with raised eyebrow why I decided to start with the challenge of Kilimanjaro. I explained that it was something that I always wanted to experience, but the timing in my life was not right --until now! I appreciate the advice from Dr. Mike Sinclair who has done this climb twice.

Congratulations!

Peter A. Keblish, Jr., MD, Division of Orthopedic Surgery, Section of Ortho Trauma, and his wife, Ruth, were recently the recipients of the Raker Memorial Award at Good Shepherd Rehabilitation Hospital. The awards serve to commemorate Good Shepherd's founders and to honor organizations and individuals who commit themselves to helping people with disabilities.

John G. Pearce, MD, Director of Breast Imaging and Chief, Section of Mammography, was recently selected by the Consumer's Research Council of America to be included in the 2002-2003 ***Guide to America's Top Radiologists***.

The Consumer's Research Council of America, a Washington, DC, based research organization, provides consumers' information guides for professional services throughout America. It is an independent organization that strives to ensure an unbiased selection for the lists of America's Best. They publish guides for psychiatrists, pediatricians, surgeons, radiologists, family doctors, OB/GYNs, optometrists, dentists and ophthalmologists.

Physicians who make the list are evaluated by experience, training, professional associations and board certification. This point system avoids subjectivity and yet enables a physician's standing and reputation within the national medical community to be part of the assessment.

Papers, Publications and Presentations

Orion A. Rust, MD, Robert O. Atlas, MD, and **L. Wayne Hess, MD,** members of the Division of Maternal-Fetal Medicine, were co-authors of "Does Cerclage Therapy Improve Perinatal Outcome in Patients with a History of Previous Preterm Birth and Cervical Changes on Second Trimester Transvaginal Ultrasound?" The abstract was selected for oral presentation at the Society for Maternal-Fetal Medicine's 23rd Annual Meeting held from February 3 to 8 in San Francisco, Calif. The article was also submitted for publication in ***The American Journal of Obstetrics and Gynecology***.

Upcoming Seminars, Conferences and Meetings

GLVIPA Quarterly General Membership Meeting

The Greater Lehigh Valley Independent Practice Association quarterly General Membership Meeting will be held on Thursday, April 10, beginning at 6 p.m., in the hospital's Auditorium at Cedar Crest & I-78.

Representatives from the Commonwealth of Pennsylvania as well as Lehigh Valley Hospital will form a panel to discuss malpractice insurance issues and tort reform.

Following the meeting, there will be an opportunity for additional discussion during the wine and cheese social.

Remember, to receive credit for your attendance, please remember to sign in.

Computer-Based Training (CBT)

The Information Services department has computer-based training (CBT) programs available for Lehigh Valley Hospital (LVH) staff. CBT programs replace the instructor-led classes previously held at LVH. A proctor will be in the room with the learner while he/she takes the CBT, but the learner will control the pace and objectives of the learning.

Topics covered by the CBT programs include:

Access 97	Windows NT 4	Excel 97
Word 97	GUI Email	
PowerPoint 97	PowerPoint 4.0	

Computer-based training takes place in **Information Services (Educational Room) at 1245 S. Cedar Crest Blvd., First Floor** and in the **Lehigh Valley Hospital-Muhlenberg I/S training room** (*off the front lobby*). The schedule of upcoming classes is as follows:

2003 CBT Sessions for 1245SCC (Educational Room): *(All sessions will be held from 8 a.m. to noon)*

May 27 June 24 July 22

2003 CBT Sessions for LVH-Muhlenberg, I/S Training Room: *(All sessions will be held from noon to 4 p.m.)*

April 17 May 15 June 19 July 17

Twelve slots are available for each session. To register for a session in email, go to either the **Forms_/LVH** or **Forms_/MHC** bulletin board, (based on your choice of site and training room). The form has all the available information in an easy to choose format, detailing titles, dates, times and locations. Simply do a "Use Form" (a right mouse option) on the **I/S Computer Educ Request** form. Complete the form indicating your desired session selection and mail the form. Shortly thereafter, you will receive a confirmation notice.

If you have any questions, please contact Information Services by calling the Help Desk at (610) 402-8303 and press option "1." Tell the representative that you need assistance with I/S education.

Medical Grand Rounds

Medical Grand Rounds are held every Tuesday beginning at noon in the Auditorium of Lehigh Valley Hospital, Cedar Crest & I-78, and via videoconference in the First Floor Conference Room at LVH-Muhlenberg. Topics to be discussed in April will include:

- April 1 - "Disputing the Myths of Whiplash Injuries"
- April 8 - "Asymptomatic Microscopic Hematuria"
- April 15 - "Early, Aggressive Treatment of Rheumatoid Arthritis - An Overview of Biologics"
- April 22 - "NSAID Gastropathy"
- April 29 - "An Integrated Approach to Insomnia"

For more information, please contact Judy Welter in the Department of Medicine at (610) 402-5200.

Department of Pediatrics

Pediatric conferences are held every Tuesday beginning at 8 a.m. Pediatric conferences are held in the Education Conference Room 1 at Lehigh Valley Hospital, Cedar Crest & I-78. Topics to be discussed in April will include:

- April 8 - Case Presentation
- April 15 - "Beyond Child's Play"
- April 22 - Senior Resident Presentation
- April 29 - "Pediatric Pain Control"

For more information, please contact Kelli Ripperger in the Department of Pediatrics at (610) 402-2540.

Who's New

The Who's New section of ***Medical Staff Progress Notes*** contains an update of new appointments, address changes, resignations, etc. Please remember to update your directory and rolodexes with this information.

Medical Staff

New Appointments

Shantanu S. Kulkarni, DO
Northeastern Rehabilitation Associates PC
Park Plaza
3400 Bath Pike, Suite 400
Bethlehem, PA 18017-2466
(610) 954-9400
Fax: (610) 954-0333
Department of Medicine
Division of Physical Medicine-Rehabilitation
Provisional Associate

Jorge A. Otero, MD
ABW Pediatric Associates
2223 Linden Street
Bethlehem, PA 18017-4806
(610) 866-2277
Fax: (610) 866-8352
Department of Pediatrics
Division of General Pediatrics
Provisional Associate

Scott R. Stoll, MD
Coordinated Health Systems
2775 Schoenersville Road
Bethlehem, PA 18017-7326
(610) 861-8080
Fax: (610) 861-2989
Department of Medicine
Division of Physical Medicine-Rehabilitation
Provisional Active

Address Changes

Reynaldo C. Guerra, MD
108 E. Northampton Street
Bath, PA 18014-1643
(610) 837-7335
Fax: (610) 837-1340

Mark F. Indzonka, MD
Pocono Heart Center
505 Independence Road, Suite B
East Stroudsburg, PA 18301-7916
(570) 421-3800
Fax: (570) 421-8014

Bruce I. Rose, MD
Infertility Solutions, PC
1275 S. Cedar Crest Blvd., Suite 3
Allentown, PA 18103-6207
(610) 776-1217
Fax: (610) 776-4149

Karen E. Senft, MD
Good Shepherd Rehabilitation Hospital
702 S. Sixth Street
Allentown, PA 18103-3204
(610) 776-3578
Fax: (610) 776-3185

New Telephone Number

Douglas F. Turtzo, MD
(610) 863-6124

New Fax Number

T. A. Gopal, MD
Fax: (610) 432-7769

Practice Changes

Jeffrey S. Brown, DO
(No longer with Muhlenberg Primary Care, PC)
Hellertown Family Health
(Lehigh Valley Physician Group)
1072 Main Street
Hellertown, PA 18055-1508
(610) 838-7069
Fax: (610) 838-7060

Gina M. Fitzsimmons, DO
(No longer with Riverside Medical Associates PC)
Riverside Family Practice
(Lehigh Valley Physician Group)
Riverside Professional Center
5649 Wynnewood Drive, Suite 203
Laurys Station, PA 18059-1124
(610) 261-1123
Fax: (610) 262-1739

Kimberly R. Sheets, MD
(No longer with Riverside Medical Associates PC)
Riverside Family Practice
(Lehigh Valley Physician Group)
Riverside Professional Center
5649 Wynnewood Drive, Suite 203
Laurys Station, PA 18059-1124
(610) 261-1123
Fax: (610) 262-1739

Continued on next page

Robert L. Stull, DO
(No longer with Muhlenberg Primary Care, PC)
(Now in solo practice)
745 Easton Road
Hellertown, PA 18055-1500
(610) 838-3130
Fax: (610) 838-3022

Status Changes

Koroush Khalighi, MD
Department of Medicine
Division of Cardiology
From: Affiliate
To: Provisional Active

Carl A. Lam, MD
Department of Obstetrics and Gynecology
Division of Gynecology
From: Active
To: Honorary

Nancy R. Lembo, DO
Department of Medicine
Division of Physical Medicine-Rehabilitation
From: Affiliate
To: Provisional Active

Luke CK Yip, MD
Department of Surgery
Division of Cardio-Thoracic Surgery
From: Active
To: Honorary

Resignations

Robert L. DeJoseph, MD
Department of Medicine
Division of Cardiology

Christine E. Hinke, MD
Department of Medicine
Division of Physical Medicine-Rehabilitation

Lawrence Klein, MD
Department of Surgery
Division of Vascular Surgery

Anuja Singh, MD
Department of Medicine
Division of General Internal Medicine

Siva Sivakantha, MD
Department of Psychiatry
Division of Consultation-Liaison Psychiatry

Anasuya Somasundaram, MD
Department of Obstetrics and Gynecology
Division of Primary Obstetrics and Gynecology

Death

Domenic J. Vettese, DDS
Department of Surgery
Division of Oral and Maxillofacial Surgery
Honorary

Allied Health Staff

New Appointments

Melissa M. Bach, RN
Registered Nurse
(The Heart Care Group, PC - Donald J. Belmont, MD)

Will Boucharel
Intraoperative Neurophysiological Monitoring Specialist
(Surgical Monitoring Associates, Inc)
(Supervising Physician: Mark C. Lester, MD)

Cheryl A. Bowman, CRNA
Certified Registered Nurse Anesthetist
(Lehigh Valley Anesthesia Services, PC - Thomas M. McLoughlin, Jr., MD)

Marie A. Boyle
Dental Assistant
(Supervising Physician: Marsha A. Gordon, DDS)

Kevin T. Chernesky, CRNA
Certified Registered Nurse Anesthetist
(Lehigh Valley Anesthesia Services, PC - Thomas M. McLoughlin, Jr., MD)

Donald G. Connell, CRNA
Certified Registered Nurse Anesthetist
(Lehigh Valley Anesthesia Services, PC - Thomas M. McLoughlin, Jr., MD)

Jocelyn J. Egge, PA-C
Physician Assistant-Certified
(Lehigh Valley Nephrology Associates - Joseph M. Jacobs, MD)

Thomas D. Giovinazzo, PA-C
Physician Assistant-Certified
(Lehigh Valley Hospital-Muhlenberg)
(Supervising Physician: Anthony M. Urbano, MD)
(Substitute Supervising Physician: Fernando M. Garzia, MD)

Continued on next page

Donna M. Kuhn, CRNP
Certified Registered Nurse Practitioner
(Gynecologic Oncology Specialists - Richard M. Boulay, MD)

Theodore J. Lengyel, CRNA
Certified Registered Nurse Anesthetist
(Lehigh Valley Anesthesia Services, PC - Thomas M. McLoughlin, Jr., MD)

Michael C. Loomis, CRNA
Certified Registered Nurse Anesthetist
(Lehigh Valley Anesthesia Services, PC - Thomas M. McLoughlin, Jr., MD)

Corey J. Seyler, PA-C
Physician Assistant-Certified
(Coordinated Health Systems - Leigh S. Brezenoff, MD)

Renee A. Troyan, RN
Registered Nurse
(The Heart Care Group, PC - Donald J. Belmont, MD)

Change of Supervising Physician

Karen A. Moskowitz, CRNP
Certified Registered Nurse Practitioner
(Peters, Caccese, Scott & Slompak)
From: Steven A. Scott, MD
To: David M. Caccese, MD

Change of Supervising Physician and Group

Constance Molchany, CRNP
Certified Registered Nurse Practitioner
From: Healthworks - Basil Dolphin, MD
To: LOVAR Department - John E. Castaldo, MD

Robert L. Williams, PA-C
Physician Assistant-Certified
From: Valley Sports & Arthritis Surgeons - David Sussman, MD
To: Coordinated Health Systems - Leigh S. Brezenoff, MD

Additional Supervising Physician

Michael F. Altrichter
Surgical Technician
(Sadr Heart & Lung Surgeons - Farrokh S. Sadr, MD)
(Additional Supervising Physician - Geary L. Yeisley, MD)

Christine J. Breithoff
Certified Coder
(RMS Physician Services Corporation)
(Additional Supervising Physician: Lawrence W. Bardawil, MD)

Resignations

Carol K. Carbone, RN
Registered Nurse
(The Heart Care Group, PC)

Elizabeth E. Davies, PA-C
Physician Assistant-Certified
(Surgical Specialists of the Lehigh Valley)

Carla M. Donkus, CRNP
Certified Registered Nurse Practitioner
(Gynecologic Oncology Specialists)

Paulette S. Dorney, RN
Registered Nurse
(Lehigh Valley Cardiology Assoc)

Robin M. Dunstan, PA-C
Physician Assistant-Certified
(Coordinated Health Systems)

Joanne M. Ehly, CRNP
Certified Registered Nurse Practitioner
(LOVAR Research)

Regina M. Fina, RN
Registered Nurse
(Colon-Recal Surgery Associates, PC)

David J. Grazio, PA-C
Physician Assistant-Certified

Wendy D. Grube, CRNP
Certified Registered Nurse Practitioner
(OB-GYN at Trexlertown, PC)

Eileen M. Klang, RN
Registered Nurse
(College Heights OBGYN Associates, PC)

Terre L. Moyer
Speech Pathologist
(Easter Seal Society of LV)

Tina M. Paganetti-Albino, CST
Certified Surgical Technician
(Lehigh Valley Ophthalmic Associates)
(Effective 4/30/2003)

Danielle M. Palmieri, PA-C
Physician Assistant-Certified
(LVPG-Emergency Medicine)

Jean D. Rohal, CRNP
Certified Registered Nurse Practitioner
(Effective 4/30/2003)

Samuel C. Strantzas
Intraoperative Neurophysiologic Monitoring Specialist
(Surgical Monitoring Associates, Inc)

Topic: Privacy Rule Takes Effect April 14, 2003

The Health Insurance Portability and Accountability Act's Final Privacy Rule goes into effect April 14th, 2003. The Rule establishes guidelines on how a covered entity uses and discloses protected health information (PHI), and creates patient rights related to accessing health information. Below is a checklist to assist you in your compliance efforts based on requirements specified in the Privacy Rule.

- ❑ Designate a **Privacy Officer**
- ❑ Develop a **Notice of Privacy Practices**
  - o It must be posted in the Practice
  - o It must be provided to patients upon first service delivery date on or after April 14, 2003. It only needs to be given to the patient once, not at every encounter.
- ❑ Ensure **Authorization form for Release of Information** meets HIPAA requirements (the general requirements include an identification of class of persons making the disclosure, class of persons to whom the disclosure may be made, information to be disclosed, expiration date or expiration event, purpose, statement of the individual's right to revoke the authorization in writing, the exceptions to the right to revoke, a re-disclosure statement, and a statement describing the ability or inability to condition treatment, payment, enrollment, or eligibility for benefits on signing an authorization form)
- ❑ Provide **Education** to your staff on Privacy Policies and Practices
- ❑ Define a process for allowing patients to **Access and Amend** their records when requested
- ❑ Define a method for **Tracking Disclosures** other than those related to treatment, payment or health care operations. The disclosures that need to be tracked are generally those required by law (i.e., reporting patients with communicable diseases to the local health bureau)
- ❑ Implement **Reasonable Physical and Technical Safeguards** to ensure minimum disclosures of PHI (i.e., password protect personal digital assistants (PDAs) notebooks and other devices containing PHI, place patient charts in a box outside an exam room facing the wall rather than having PHI about the patient visible to anyone who walks by, etc.)
- ❑ Amend **Business Associate Agreements** (If an agreement is in existence as of October 15, 2002, you have until April 2004 or when the agreement is renewed, whichever date is sooner, to include the business associate language)

As a side note, **HIPAA's final Security regulations were published in the Federal Register on February 20, 2003.** The Security Rule applies only to electronic protected health information in storage and transmission. To view the final rule, go to www.access.gpo.gov/su_docs/fedreg/a030220c.html under HHS. Health care providers have until April 20th, 2005 to be in compliance with this Rule.

THERAPEUTICS AT A GLANCE

The following actions were taken at the February 2003 Therapeutics Committee Meeting - Joseph Ottinger, R.Ph., MS, MBA, Janine Barnaby, R.Ph., Jenny Boucher, Pharm. D., Jason Laskosky, Pharm.D., Viraj Patel, Pharm.D., Heidi Mayville, Pharm.D., Fred Pane, R.Ph., Robert Begliomini, Pharm .D

Therapeutic/Autosubstitution (Anti-Infective)

The Therapeutics Committee has approved the following change with support from the Department of Infectious Disease.

Aztreonam (Azactam®) will be converted to cefepime (Maxipime®) in the following manner:

- Aztreonam 1gm IV q8h to cefepime 1gm IV q12h
  - (1gm q24h if est crcl < 60ml/min)
- Aztreonam 2gm IV q8h to cefepime 2gm IV q12h
  - (2gm q24h if est crcl < 60ml/min or 1gm/d if on HD or PD or CVVH)

Exceptions include documented PCN/cephalosporin allergy or documented cefepime resistance.

- It is important to acknowledge that while cross-reactivity of aztreonam with other beta-lactam antibiotics is rare; this drug should be administered with caution to any patient with a history of hypersensitivity to beta-lactams (e.g. penicillins, cephalosporins, and/or carbapenems).

Cefepime, a forth generation cephalosporin, has a broad spectrum of activity encompassing a wide range of gram-positive and gram-negative bacteria. Conversely, aztreonam is a monobactam antibiotic with activity limited to gram-negative microorganisms. In terms of gram-negative coverage, cefepime and aztreonam have nearly identical spectrums of activity. One exception is cefepime's superior coverage against pseudomonas (73% vs. 32% on LVH antibiogram).

LVH 2001 Antibiogram (inpatients and outpatients)

Organism	Aztreonam	Cefepime
Acinetobacter anitratus/baumanii	*	41%
Citrobacter freundii complex	*	100%
Enterobacter aerogenes	*	100%
Enterobacter cloacae	*	97%
E. coli	*	100%
Klebsiella oxytoca	*	100%
Klebsiella pneumonia	*	98%
Morganella morganii	*	100%
Proteus mirabillis	*	99%
Pseudomonas aeruginosa	32%	73%
Serratia marcescens	*	100%

* Not tested

Benefits for this substitution include:

- Improved antipseudomonal activity without otherwise compromising spectrum of activity.
- Decreased doses hung (q8h to q12h) dosing interval.
- Decreased selection for resistant organisms such as VRE and enterobacter. Resistance emergence of these pathogens is well documented with the 3rd generation cephalosporins and has been associated with aztreonam as well. Cefepime has shown no trend in this direction.
- Decreased cost of therapy.

Therapeutic Drug Substitution Addition

The Therapeutics Committee has approved the following addition to a previous therapeutic drug substitution of the COX-2 inhibitor class.

Background: Bextra (valdecoxib) is a COX-2 inhibitor with FDA indications for osteoarthritis (OA), rheumatoid arthritis (RA) and dysmenorrhea. Vioxx (rofecoxib), the LVHHN COX-2 inhibitor formulary alternative of choice, has FDA indications for OA, RA, dysmenorrhea, and acute pain. There are no direct comparison studies on evidence of superiority between COX-2 inhibitors at this time.

Previously, the therapeutics committee approved the therapeutic substitution of valdecoxib to rofecoxib as follows:

valdecoxib 10mg daily to rofecoxib 25mg daily
valdecoxib 20mg twice daily to rofecoxib 50mg daily

The off-label dosing method of valdecoxib 20mg daily was considered for therapeutic substitution equivalency after reviewing study data concerning rofecoxib dosing. Schnitzer et al [1] found that RA patients receiving either rofecoxib 25mg or 50mg daily showed similar improvements in efficacy measurements following eight weeks of therapy. While both were significantly superior to placebo, rofecoxib 50mg daily did not show a statistically significant advantage over rofecoxib 25mg daily. Therefore, off-label dosing schemes of valdecoxib 20mg daily will be substituted to rofecoxib 25mg daily.

1. Schnitzer TJ et al. The Safety Profile, Tolerability, and Effective Dose Range of Rofecoxib in the Treatment of Rheumatoid Arthritis. Clinical Therapeutics 1999:21(10);1688-1702.

List of Dangerous Drug Abbreviations, Dose Designations

A list including abbreviations, acronyms and symbols ***RECOMMENDED NOT TO BE USED*** at Lehigh Valley Hospital was approved by the Therapeutics Committee on February 19, 2003.

Table Warns Against Dangerous Drug Abbreviations, Dose Designations

The Institute for Safe Medicine Practices recently developed a table showing dangerous abbreviations and dose designations that, for medication safety reasons, should not be used.

(reprinted with permission of the Institute for Safe Medicine Practices)

Abbreviation/ Dose Expression	Intended Meaning	Misinterpretation	Correction
q6PM, etc.	every evening at 6 PM	Misread as every six hours.	Use 6 PM "nightly."
q.o.d. or QOD	every other day	Misinterpreted as "q.d." (daily) or "q.i.d. (four times daily) if the "o" is poorly written.	Use "every other day."
sub q	subcutaneous	The "q" has been mistaken for "every" (e.g., one heparin dose ordered "sub q 2 hours before surgery" misunderstood as every 2 hours before surgery).	Use "subcut." or write "subcutaneous."
SC	subcutaneous	Mistaken for SL (sublingual).	Use "subcut." or write "subcutaneous."
U or u	unit	Read as a zero (0) or a four (4), causing a 10-fold overdose or greater (4U seen as "40" or 4u seen as 44").	"Unit" has no acceptable abbreviation. Use "unit."
IU	international unit	Misread as IV (intravenous).	Use "units."
cc	cubic centimeters	Misread as "U" (units).	Use "mL."
x3d	for three days	Mistaken for "three doses."	Use "for three days."
BT	bedtime	Mistaken as "BID" (twice daily).	Use "hs."
ss	sliding scale (insulin) or ½ (apothecary)	Mistaken for "55."	Spell out "sliding scale." Use "one-half" or use "½."
> and <	greater than and less than	Mistakenly used opposite of intended.	Use "greater than" or "less than."
/ (slash mark)	separates two doses or indicates "per"	Misunderstood as the number 1 ("25 unit/10 units" read as "110" units.	Do not use a slash mark to separate doses. Use "per."
Name letters and dose numbers run together (e.g., Inderal40 mg)	Inderal 40 mg	Misread as Inderal 140 mg.	Always use space between drug name, dose and unit of measure.
Zero after decimal point (1.0)	1 mg	Misread as 10 mg if the decimal point is not seen.	Do not use terminal zeros for doses expressed in whole numbers.
No zero before decimal dose (.5 mg)	0.5 mg	Misread as 5 mg.	Always use zero before a decimal when the dose is less than a whole unit.

Abbreviation/ Dose Expression	Intended Meaning	Misinterpretation	Correction
Apothecary symbols	dram minim	Misunderstood or misread (symbol for dram misread for "3" and minim misread as "mL").	Use the metric system.
AU	aurio uterque (each ear)	Mistaken for OU (oculo uterque—each eye).	Don't use this abbreviation.
D/C	discharge discontinue	Premature discontinuation of medications when D/C (intended to mean "discharge") has been misinterpreted as "discontinued" when followed by a list of drugs.	Use "discharge" and "discontinue."
Drug names			Use the complete spelling for drug names.
ARA-A	vidarabine	cytarabine (**ARA-C**)	
AZT	zidovudine (**RETROVIR**)	azathioprine	
CPZ	**COMPAZINE** (prochlorperazine)	chlorpromazine	
DPT	**DEMEROL-PHENERGAN-THORAZINE**	diphtheria-pertussis-tetanus (vaccine)	
HCl	hydrochloric acid	potassium chloride (The "H" is misinterpreted as "K.")	
HCT	hydrocortisone	hydrochlorothiazide hydrocortisone (seen as HCT250 mg)	
HCTZ	hydrochlorothiazide	morphine sulfate	
MgSO4	magnesium sulfate	magnesium sulfate	
MSO4	morphine sulfate	mitoxantrone	
MTX	methotrexate	tetracaine, **ADRENALIN**, cocaine	
TAC	triamcinolone	morphine sulfate	
ZnSO4	zinc sulfate		
Stemmed names		sodium nitroprusside infusion	
"Nitro" drip	nitroglycerin infusion	**NORFLEX** (orphenadrine)	
"Norflox"	norfloxacin		
µg	microgram	Mistaken for "mg" when handwritten.	Use "mcg."
o.d. or OD	once daily	Misinterpreted as "right eye" (OD—oculus dexter) and administration of oral medications in the eye.	Use "daily."
TIW or tiw	three times a week.	Mistaken as "three times a day."	Don't use this abbreviation.
per os	orally	The "os" can be mistaken for "left eye."	Use "PO," "by mouth," or "orally."
q.d. or QD	every day	Mistaken as q.i.d., especially if the period after the "q" or the tail of the "q" is misunderstood as an "i."	Use "daily" or "every day."
qn	nightly or at bedtime	Misinterpreted as "qh" (every hour).	Use "nightly."
qhs	nightly at bedtime	Misread as every hour	Use "nightly."

Blood and Transfusion Subcommittee Update

1. **Plasma**
   When ordering "PLASMA," please remember that it takes 45 minutes to thaw.

2. **Chest** Guidelines (Sixth ACCP Consensus Conference on Antithrombotic Therapy)
   The recommendations of the Sixth ACCP Consensus Conference on Antithrombotic Therapy are as follows. If these guidelines are followed, it may contribute to a decreased need for blood products. These guidelines have been reviewed at the January 2003 Therapeutics Subcommittee and February 2003 Therapeutics Committee.

RECOMMENDATIONS

Practical Dosing

1. For the initiation of and maintenance dosing of warfarin, commence therapy with an average maintenance dose of 5 mg (grade 2A compared to a dose of 10 mg). Starting doses of < 5 mg might be appropriate for elderly patients, patients with impaired nutrition or liver disease, and in patients with a high risk for bleeding.

Management of Nontherapeutic INRs

1. For patients with INRs greater than the therapeutic level but < 5.0 who do not have significant bleeding, lower the dose or omit a dose and resume therapy at a lower dose when the INR is at the therapeutic level. If the INR is only minimally greater than the therapeutic range, no dose reduction may be required (grade 2C).
2. For patients with INRs > 5.0 but < 9.0 with no significant bleeding, omit the next one or two doses, monitor the INR more frequently, and resume therapy at a lower dose when the INR is at the therapeutic level. Alternatively, omit the dose and administer vitamin K_1, 1 to 2.5 mg orally, particularly if the patient is at increased risk of bleeding. If more rapid reversal is required because the patient requires urgent surgery, administer vitamin K_1, 2 to 4 mg orally, with the expectation that a reduction of the INR will occur in 24 h. If the INR is still high, administer an additional dose of vitamin K_1, 1 to 2 mg orally (all grade 2C compared with no treatment).
3. For patients with INRs > 9.0 with no significant bleeding, hold off on warfarin therapy and administer a higher dose of vitamin K_1, 3 to 5 mg orally, with the expectation that the INR will be reduced substantially in 24 to 48 h. Monitor the INR more frequently and administer additional vitamin K_1 if necessary. Resume therapy at a lower dose when the INR reaches the therapeutic level (all grade 2C compared with no treatment).
4. For patients with INRs > 20 with serious bleeding, hold off on warfarin therapy and administer vitamin K_1, 10 mg by slow IV infusion, supplemented with fresh plasma or prothrombin complex concentrate, depending on the urgency of the situation. Administration of vitamin K_1 can be repeated every 12 h (grade 2C).
5. For patients with life-threatening bleeding, hold off on warfarin therapy and administer prothrombin complex concentrate supplemented with vitamin K_1, 10 mg by slow IV infusion. Repeat this treatment as necessary, depending on the INR (grade 2C).

These recommendations remain unchanged from the 1998 ACCP recommendations. If the continuation of warfarin therapy is indicated after the administration of high doses of vitamin K_1, then heparin can be given until the effects of vitamin K_1 have been reversed and the patient becomes responsive to warfarin.

Management of Oral Anticoagulation During Invasive Procedures

1. For patients with low risk of thromboembolism (*eg*, patients without venous thromboembolism for > 3 months or patients who have experienced atrial fibrillation who do not have a history of stroke), stop warfarin therapy approximately 4 days before surgery, allow the INR to return to a near-normal level, briefly administer postoperative prophylaxis (if the intervention itself creates a higher risk of thrombosis) using low-dose heparin, 5,000 U SC, and simultaneously begin warfarin therapy (grade 2C).
2. For patients with intermediate risk of thromboembolism, stop warfarin therapy approximately 4 days before surgery, allow the INR to fall, cover the patient with low-dose heparin, 5,000 U SC, beginning 2 days before surgery or with a prophylactic dose of LMWH, and then commence low-dose heparin (or LMWH) and warfarin therapy after surgery (grade 2C).
3. For patients with high risk of thromboembolism (*eg*, patients with a recent [< 3 months] history of venous thromboembolism, patients with a mechanical cardiac valve in the mitral position, or an old model of cardiac valve [ball/cage]), stop warfarin therapy approximately 4 days before surgery, allow the INR to return to a normal level, begin therapy with full-dose heparin or full-dose LMWH as the INR falls (approximately 2 days before surgery). Heparin can be administered as an SC injection on an outpatient basis, can then be given as a continuous IV infusion after hospital admission in preparation for surgery, and can be discontinued 5 h before surgery with the expectation that the anticoagulant effect will have worn off at the time of surgery. It is also possible to continue the administration of SC heparin or LMWH and to stop therapy 12 to 24 h before surgery with the expectation that the anticoagulant effect will be very low or will have worn off by the time of surgery (all grade 2C).
4. For patients with low risk of bleeding, continue warfarin therapy at a lower dose and operate at an INR of 1.3 to 1.5, an intensity that has been shown to be safe in randomized trials of gynecologic and orthopedic surgical patients. The

dose of warfarin can be lowered 4 or 5 days before surgery. Warfarin therapy then can be restarted after surgery and supplemented with low-dose heparin, 5,000 U SC, if necessary (grade 2C).

5. For patients undergoing dental procedures who are not considered to be at high risk for bleeding, we recommend that warfarin therapy not be discontinued. In patients at high risk for bleeding, we recommend that warfarin therapy be discontinued (all grade 2C).
6. For patients undergoing dental procedures in whom local bleeding must be controlled, tranexamic acid or epsilon amino caproic acid mouthwash can be administered without interrupting anticoagulant therapy (grade 2B).

Risk Factors for Adverse Events (Hemorrhage)

1. For individuals who are otherwise good candidates for anticoagulation therapy, do not withhold therapy because of a patient's age (grade 1C).
2. Monitor elderly patients more carefully to maximize the TTR.

Models of Anticoagulation Management

1. In comparing UC with AMS, we recommend that clinicians employ a systematic process to manage oral anticoagulation dosing that includes a knowledgeable provider, reliable PT monitoring, and an organized system of follow-up, patient communication, and education (grade 1C).
2. POC PST is for selected individuals who are willing and able to perform self-testing and are suitably trained. We recommend this model as an alternative to a UC model of INR monitoring and management to achieve a greater TTR (grade 2B).
3. Computer software programs for dose management must be considered individually based on well-designed clinical outcome studies. We recommend consideration of those software programs demonstrated to provide dosing decisions equivalent to a better than physician management, especially in high-volume anticoagulation programs (grade 2B).

The Last Word...

Tips and Techniques for the Lastword™ User, by Kim Szep, RN, BSN

April, 2003 – Volume 2, Issue 6

New Patient Evaluation Order Sets

The CAPOE team is continually making system improvements to aid physicians with order entry. To this end, three new order sets have been added. They are the ***Fever, Anemia,*** and ***Pulmonary Embolism Evaluation Order Sets***. These sets group potential orders together (including those from Imaging, Blood Bank, Laboratory, and Microbiology) that are common to these specific diagnoses.

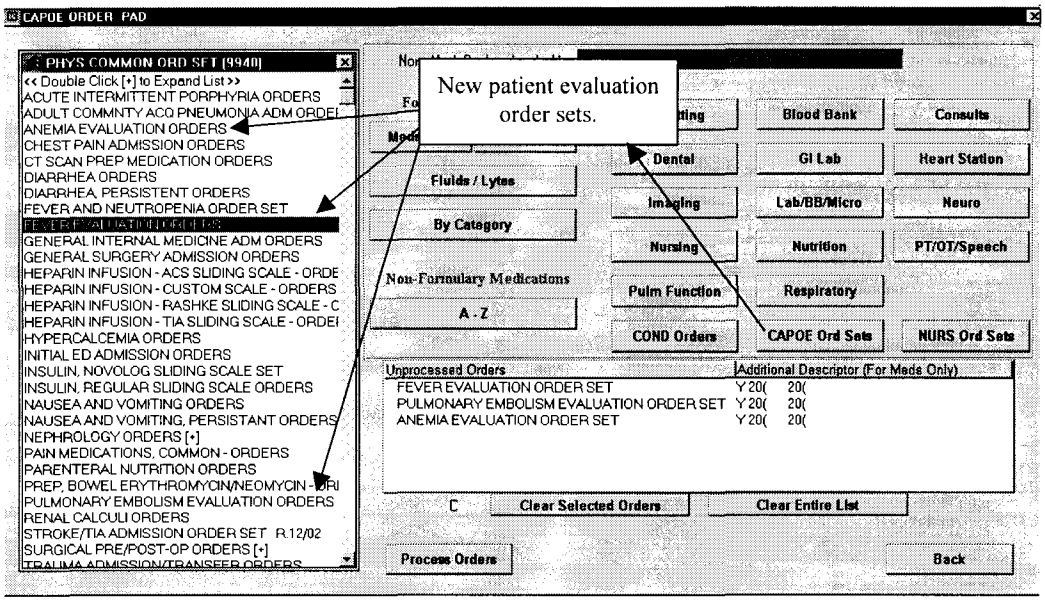


Figure 1 – Ordering the new patient evaluation order sets

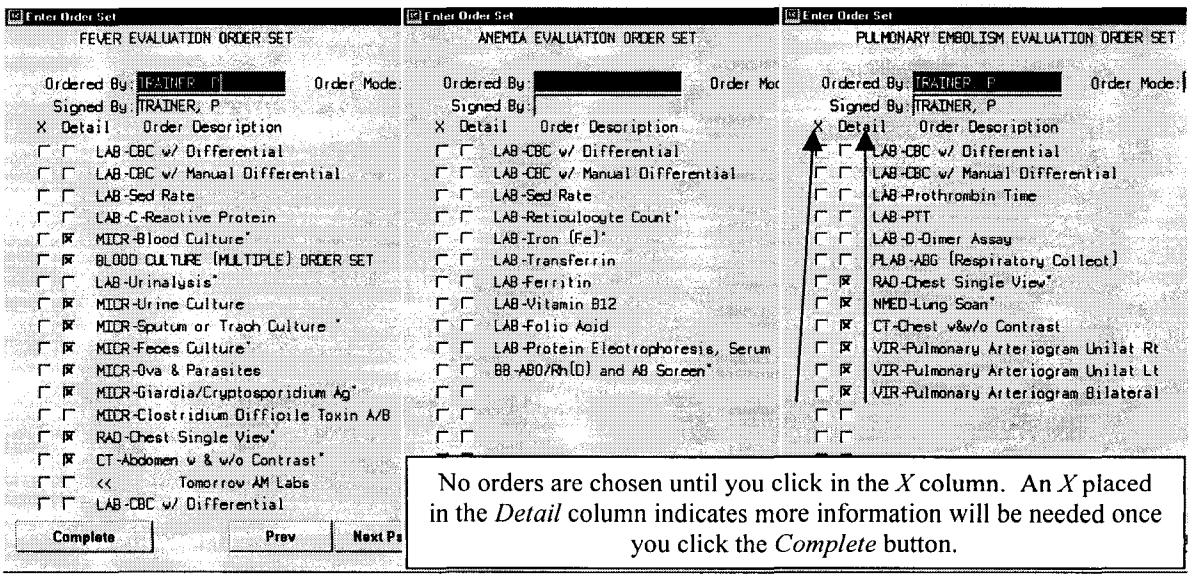


Figure 2 – The new evaluation order sets, side by side for comparison

To access these new order sets, click on the *Orders* tab from the *Physician Base* screen. Next, click on the *CAPOE Ord Sets* button. Locate the desired order set (see Figure 1), then double click to place it in the *Unprocessed Orders* box. When you have finished selecting orders, click the *Process Orders* button. In Figure 2, the three new order sets are placed side by side for comparison. Choose your orders by clicking in the *X* column. When finished, click the *Complete* button. As with any order, when more information is required the order processing will halt and the system will request additional information from you.

CAPOE FAQs

Q Why are some blocks in the *Viewer* yellow?

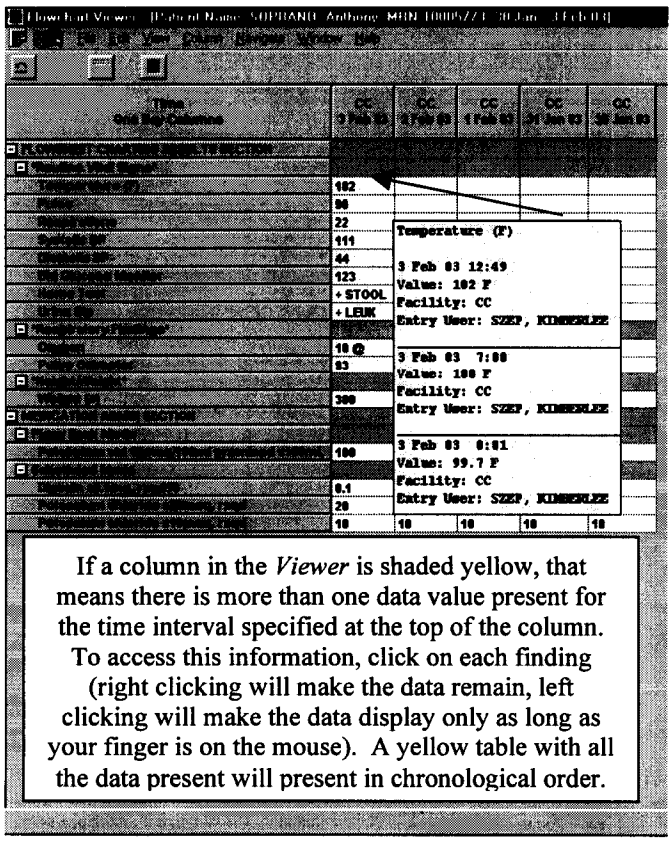


Figure 3 – Yellow values in the *Viewer*

A Depending on how your *Viewer* time preferences are set, there may be more than one piece of data present in each column (see Figure 3). In the *Viewer*, cells with more than one data point are colored yellow. To obtain the additional information, simply click on the value you would like to see. A yellow box will display, containing the additional data in chronological order. For example, in Figure 3, three temperatures are charted throughout the same day. **FYI**, if you *left* mouse click on the value it will display for only as long as your finger is on the button, and if you *right* mouse click the values will display until you click elsewhere.

Q I sorted orders on the *CAPOE Order Profile*, why are they not in the same order when I go to the next page?

A You can sort by any of the column headers by clicking on the gray boxes. However, the default display on the *CAPOE Order Profile* is for the category of *MEDS* to be listed first. When you scroll to the bottom of the *CAPOE Order Profile* screen on a patient that has many orders, you will need to click on the down arrow button to continue your review on the next page (see Figure 4). The computer will then default back to *MEDS* as the first category listed on the next screen, and you will need to re-sort if desired. If the down arrow button is not present, your patient does not have a second page of orders.

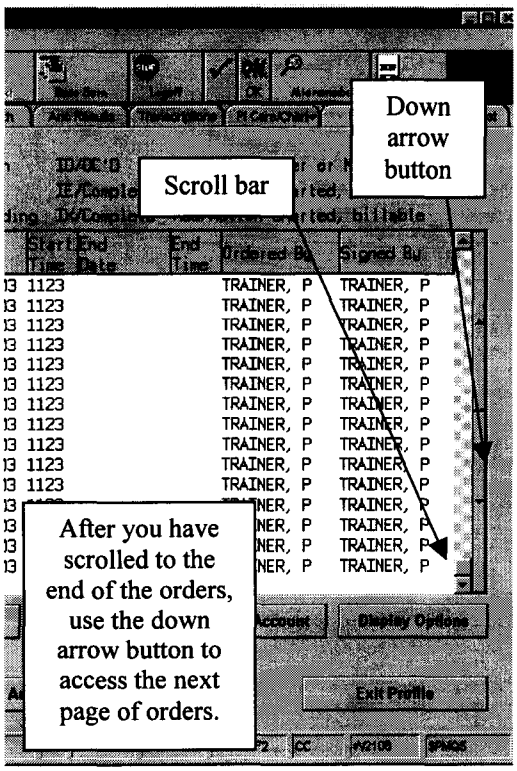


Figure 4 – The scrolling arrows

Q How can I check on a patient's meds, labs, and allergies while entering medication orders without losing my place?

A When ordering medications (whether from within an order set or individually), take note to the *Review* box near the bottom left side of the *Place a Medication Order* screen. Within this box are four buttons (*Allergies, Lab Results, Pending Lab,* and *Med Profile*). You may click on any of these to obtain the information you need. On each screen you are redirected to, there is a *Back* button. Clicking this button will return you to the medication entry screen, where you can proceed with the order or click on another *Review* button.

NEW – Viewlets on LVH Intranet

Viewlets are now available on the *Lastword for Physicians* Web page on the Lehigh Valley Hospital Intranet.

Q What is a *Viewlet*?

A *Viewlets* are step-by-step training demonstrations you can watch in your Web browser.

Q How do I use them?

A *Viewlets* are accessed through the LVHHN Intranet using the steps below:

1. Open Internet Explorer and go to www.lvh.com (the hospital home page).

2. Click on the ***RESOURCES*** drop-down menu and select ***GENERAL***. From the ***GENERAL*** drop-down menu, click on ***Lastword for Physicians***. *The Lastword for Physicians* Web page opens.

3. Click on the ***Viewlets*** link. The *LVHHN VIEWLETS* Web page opens. A list of links to *Viewlets* appears on the page.

4. Click on the desired *Viewlet*. The *Viewlet* opens your default Web browser and runs the demonstration.

If you have questions regarding *Viewlets* or have suggestions for new ones, please contact *Viewlet* author **Carolyn Suess, RN**, as listed below in the Help section.

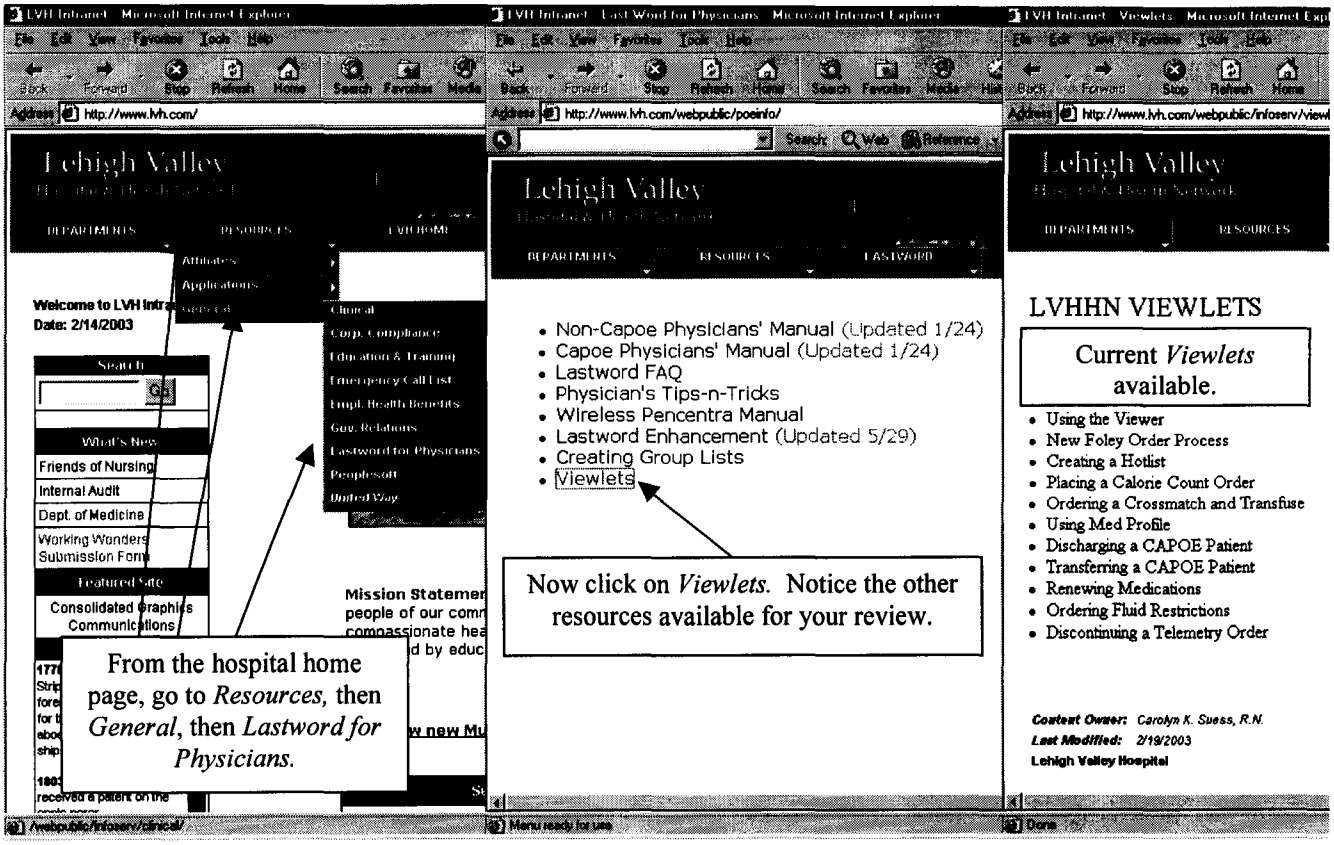


Figure 5 – Accessing *Viewlets* and other on-line help for Lastword and CAPOE.

I Need Help...

Should you have difficulties or questions while entering CAPOE orders, please page the on-call CAPOE team member using the **CAPOE Help Line** at **x 8303, option #9**. This service is available 24 hours a day, seven days a week. If you have other hardware, software, or password issues, please choose **option #1** so we may provide you with optimal, timely service.

The CAPOE staff is on-site on CAPOE units Monday through Friday during daytime hours, and weekends during the morning/early afternoon rounding hours. Please feel free to ask for any assistance you may need.

A Physician Software Educator is also available in the Medical Staff Lounge two mornings per month. The hours are posted in the Lounge. She can help you place orders on the dedicated practice workstation and answer any questions you may have. The Educators will also be happy to provide any remedial training you may require, as well as additional reference materials.

If you have training needs that pertain only to the Lastword (Phamis) system, please call **x1703.** Arrangements can be made for training at your convenience.

Physician Software Educators on staff are:

Lynn Corcoran-Stamm – x1425
Carolyn K. Suess, RN – x1416
Kim Szep, RN – x1431

LEHIGH VALLEY
HOSPITAL AND
HEALTH NETWORK

Cedar Crest & I-78
P.O. Box 689
Allentown, PA 18105-1556

Non-Profit Org.
U.S. Postage
PAID
Allentown, PA
Permit No. 1922

Medical Staff Progress Notes

Medical Executive Committee

Medical Staff Progress Notes **is published monthly to inform the Medical Staff of Lehigh Valley Hospital and employees of important issues concerning the Medical Staff.**

Articles should be submitted to Janet M. Seifert, Medical Staff Services, Lehigh Valley Hospital, Cedar Crest & I-78, P.O. Box 689, Allentown, PA 18105-1556, by the 15th of each month. If you have any questions about the newsletter, please call Mrs. Seifert at (610) 402-8590.